

**HRSA Health Center Ongoing Outreach and Enrollment (O/E) Assistance
Frequently Asked Questions (FAQs)
Updated July 24, 2014**

These FAQs address questions related to HRSA's ongoing O/E expectations of health centers beyond the initial open enrollment period and into the next open enrollment period, beginning November 15, 2014.

For questions not addressed below, please contact BPHC's Outreach and Enrollment Assistance Team at bphc-oe@hrsa.gov.

Expectations for Ongoing O/E Activities

1) Can you summarize the O/E funding that has been provided to health centers? Will health centers continue to receive O/E funding?

In July 2013 (FY 2013 funding), HRSA awarded \$150 million to health centers through the O/E supplemental funding for a 12-month period from July 1, 2013 through June 30, 2014. These awards included \$5,000 in one-time funds.

In December 2013 (FY 2014 funding), HRSA awarded an additional \$58 million in one-time O/E supplemental funding to health centers.

Additionally, in FY 2014, HRSA has included the FY 2013 ongoing (excluding one-time), O/E supplemental funding into health center base awards, with a Notice of Award (NoA) term specifying that funds must be used "to support continued O/E assistance activities funded initially in FY 2013." The amount of O/E funds indicated in the FY 2014 NoA is pro-rated from July 1, 2014 to the start of the grantee's next budget period start date, less the one-time funds.

In FY 2015 and beyond, HRSA anticipates that O/E funds will be annualized to the amount that matches the amount awarded in July 2013 (excluding the one-time funding). This is reflected as the Recommended Future Support (RFS) commitment on O/E awardees' most recent Notice of Award.

2) Will PCAs continue to receive O/E funding to support health centers?

Yes. HRSA expects to similarly include O/E funding into primary care association base awards to continue their work to support health center O/E assistance efforts.

3) What are HRSA's ongoing expectations for health centers' O/E activities and use of funds?

With O/E funding included into health centers' base awards, HRSA has made a commitment to outreach and enrollment as an ongoing health center activity.

HRSA expects health centers will continue to conduct in reach, outreach, and enrollment assistance throughout the year, with the understanding that during the open enrollment periods, health centers will likely have to adjust resources in order to meet the increased health center patient and service area needs during open enrollment periods.

Ongoing activities supported by O/E funding include, but are not limited to the following, as appropriate:

- Conducting in reach to uninsured eligible health center patients;
- Conducting outreach in the health center's approved service area, including promoting the health center as a resource for enrollment assistance;
- Securing access to Medicaid, CHIP and other available health, social service, pharmacy and other assistance programs;
- Assisting individuals with filing appeals and exemptions;
- Assisting individuals with requesting a special enrollment period;
- Assisting individuals with Medicaid re-enrollment;
- Assisting newly insured individuals with understanding and utilizing their insurance;
- Ensuring that the health center is appropriately designated as an assister entity as determined by applicable federal and state laws and other requirements;
- Maintaining a sufficient and competent O/E assistance worker workforce, including:
 - Ensuring that health center O/E assistance workers have met all applicable federal and state training and related requirements;
 - Providing or supporting participation in other training and related professional development;
- Planning and maintaining partnerships to maximize the impact of the health center in reaching uninsured eligible populations; and
- Identifying and incorporating lessons learned to improve the enrollment process for consumers and assisters and to more effectively target outreach to uninsured eligible populations.

4) Are health centers expected to maintain the FY 2013 level of staffing for O/E activities?

HRSA expects health centers to maintain reasonable staffing levels that: 1) allow the organization to do proactive outreach and to meet the demand for enrollment assistance and related activities throughout the year; and 2) ensure that the organization is reasonably prepared and has sufficient numbers of trained O/E assistance workers to conduct in reach and outreach activities to meet health center patient and service area needs during open enrollment periods.

5) Do I need to request approval to change how our health center budgets for or plans to conduct O/E activities?

HRSA does not require an O/E-specific budget or work plan for ongoing O/E activities. However, health centers must submit an annual overall budget and account for how federal dollars are spent.

Health centers should use their discretion in how to budget additional funding in the base award to support O/E and related activities in ways that best align with the identified need in the service area and lessons learned from the first open enrollment period and beyond. These activities and ongoing staffing commitments should fall within the parameters outlined in the Ongoing O/E Frequently Asked Questions (FAQs), available at <http://bphc.hrsa.gov/outreachandenrollment> and include ongoing O/E quarter progress reporting for the near future.

6) Do I need to seek prior approval to carry over unobligated O/E funds into our health center's FY 2014 budget period?

HRSA's Division of Grants Management provided guidance to all HRSA grantees regarding carry over of unobligated funds in late December.

Over the last few months of FY 2013 budget periods, the Health Resources and Services Administration (HRSA) awarded several types of administrative supplements to health center grantees for one or more of the following activities:

- Outreach and Enrollment (O/E)
- Migrant Health
- HIV/AIDS
- Base Adjustments

Because each of these awards was funded for a performance period of 12 months or more in FY 2013, these funds are crossing over into the FY 2014 budget period. Therefore, grantees will have unobligated balances at the end of their FY 2013 budget period. HRSA has determined that its current progress reporting mechanisms (Budget Period Renewal; Quarterly Progress Reports; UDS, etc.) provide sufficient information regarding health center grantees' ongoing efforts for each of these activities. Therefore, HRSA will NOT require submission of additional Prior Approval requests to carry over unobligated funds resulting from these supplements. Rather, health centers should report their Unobligated Balance (UOB) on the Annual Federal Financial Report (FFR) and note in the Remarks and Comments section of the FFR what portion of the UOB is the result of one or more of these supplements. No additional HRSA authorization will be required in order to continue spending for these ongoing activities as proposed and previously approved by HRSA.

Please note that supplements issued as a result of the New Access Point (NAP) competitive funding opportunity do not fall within the category described above. Therefore, any requests for carry-over NAP funding MUST be submitted for HRSA approval via the Prior Approval module in EHB.

If you have questions regarding this procedure, please contact the Division of Grants Management Operations contact listed on the last page of your Notice of Award.

7) Must individuals hired by health centers as O/E assistance workers continue to conduct only O/E-specific activities?

As noted in other FAQs (see questions 3 and 4), health centers receiving O/E funding are expected to continue O/E activities post open enrollment and be prepared to respond to increased demand for assistance in the next open enrollment period. However, during times when demand for O/E activities are lower, as appropriate, staff previously dedicated exclusively to O/E assistance may be used in to contribute to support other health center efforts to expand access to care and/or to provide comprehensive primary care services (e.g., patient/community education and other support/enabling services).

8) What are the ongoing O/E quarterly progress reporting (QPR) requirements for health centers?

For the near future, HRSA will continue to require health centers to submit QPRs. More information on

health center reporting requirements can be found in the QPR Frequently Asked Questions, located at http://bphc.hrsa.gov/outreachandenrollment/oe_qpr_faqs.pdf.

9) How should health centers account for O/E spending?

HRSA does not require separate budget reporting for O/E activities. However, HRSA expects O/E funds to be spent in accordance with a health center's approved budget and work plan, and that grantees can account for spending as needed. See Policy Information Notice (PIN) 2013-01, Health Center Budgeting and Accounting Requirements located at <http://bphc.hrsa.gov/policiesregulations/policies/pin201301.html> for more information.

10) What are HRSA expectations of health centers for the 2015 open enrollment period?

HRSA will rely on health centers to perform similar activities and perform at a similar level of effort during the next open enrollment season, beginning November 15, 2014.

11) NEW Our health center was successful at promoting the availability of health center O/E assistance to residents of our service area via earned media and mailers. Are these activities allowable under the new regulations that state that "CACs may not solicit consumers for application or enrollment assistance by going door-to-door, or through other unsolicited means of direct contact, including calling a consumer, unless the consumer initiates contact or the consumer has a pre-existing relationship with the assister organization?"

Health centers may use earned and paid media, mailers, go door-to-door or make direct calls, and other broad-based strategies to do unsolicited outreach and education to the public to promote the availability of health center enrollment assistance to non-health center patients. If a health center makes unsolicited direct calls to consumers for outreach and education purposes, the health center may not use "robocalls," meaning an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the health center or individual CAC has a pre-existing relationship with the consumer (e.g, consumer is a patient of the health center), so long as other applicable state and Federal laws are complied with. If, when providing unsolicited outreach and education to a consumer, the consumer requests assistance with application or enrollment, the assister may provide assistance at that time or follow-up with the consumer, as appropriate.

Training Requirements and Expectations

12) Will there be additional training requirements for the next open enrollment period?

CMS has proposed that assisters be required to undergo a process of recertification that will be determined by the federal or state insurance marketplace. CMS also proposes that assisters and their supporting organizations who conduct O/E activities without having completed required training may face civil monetary penalties.

13) What are HRSA's minimum training expectations for health centers?

Federally-Facilitated Marketplaces: Health centers in federally-facilitated marketplaces (FFMs) must, at

a minimum, apply for and be designated as a certified application counselor (CAC) organization and ensure that all health center O/E assistance workers successfully complete all required federal CAC training and any additional required state training.

State Partnership Marketplaces: In state partnership marketplaces (SPMs), health center O/E assistance workers may be required to complete a state-specific training in lieu of and/or in addition to the federal CAC training in order to facilitate enrollment.

State-Based Marketplaces: At a minimum, health centers and health center O/E assistance workers in state-based marketplaces (SBMs) must complete all individual training and any other individual and organizational requirements for individuals who will assist with enrollment into affordable insurance options offered through the Marketplace, Medicaid and CHIP in that state.

Additional Training: Health center O/E assistance workers who have the option to participate in training more extensive than that which is required for CACs or the state equivalent (e.g., navigator training) can participate and perform any additional functions afforded by that higher level of training, as long as the activities they perform remain consistent with the intent of HRSA O/E funding and are consistent with all federal and state laws and requirements.

14) If I am in a FFM state, does my health center need to be designated as a CAC organization before my O/E assistance workers can be trained?

Yes. If you haven't already done so, you should complete an application to become a CAC organization. The CAC application is located at <http://marketplace.cms.gov/help-us/cac-apply.html>. FAQs related to this application process are located at <http://marketplace.cms.gov/help-us/common-qandas-about-cac-designation.pdf>. You can send questions and issues related to the CAC application to CMS at cacquestions@cms.hhs.gov.

If you are in a SPM or SBM, you must comply with the organization and individual assister requirements as determined by your state.

15) Where can I learn more about training and other training requirements in my state?

Primary care associations are available to help health centers to better understand the O/E assistance worker training requirements in your state. Contact information for the PCA in your state is located at <http://bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html>. You can also contact your state marketplace for additional information.

16) Must health center O/E assistance workers who are not supported by HRSA funding complete assister training?

Yes. Anyone performing enrollment assistance through the federal or state marketplace on behalf of the health center, including health center staff, volunteers, or contracted individuals, must, at a minimum, complete all training requirements applicable for enrollment assisters in that state. This includes look-alikes and other health centers that did not receive HRSA O/E supplemental funds.

17) If my staff are only providing assistance with Medicaid or CHIP enrollment directly through the state Medicaid agency, must they complete all training applicable to providing assistance with enrollment through the marketplace?

It is up to each health center to ensure that staff are appropriately prepared to assist with Medicaid enrollment through their state Medicaid agency and any associated requirements. HRSA strongly encourages that eligibility assistance workers be certified to also assist with enrollment through the marketplace, even if it is not their primary responsibility.

18) Our state law requires that organizations that facilitate enrollment be licensed and perform background checks on all individuals providing enrollment assistance. Does HRSA require that our organization be licensed and/or complete background checks on employees?

HRSA requires that health centers and their O/E assistance workers comply with all applicable state laws and requirements that apply to their O/E assistance role in their state.

Sliding Fee Scale Requirements

19) What should we advise patients who do not want to pursue affordable insurance options through the Marketplace in favor of continuing to receive services at the health center on a sliding fee discount scale (SFDS)?

Health centers should educate consumers about affordable insurance options, including the benefits that extend beyond the services provided by the health center (e.g., access to specialty care and hospitalization) and provide assistance with enrollment for eligible individuals. However, if a current or new patient is not able to, is exempt from, or chooses not to pursue affordable insurance coverage, the health center must continue to serve that patient, assess eligibility for the SFDS based on family size and income, and charge the patient in accordance with the health center's SFDS for the service(s) provided, as appropriate.

20) Will the sliding fee discount scale (SFDS) Health Center Program requirement be made obsolete by the Affordable Care Act (ACA)?

No. As the ACA continues in future years, there will be individuals who are not eligible to enroll, are exempted from the mandatory coverage requirement, and/or who may choose not to enroll. Health centers must continue to assess these individuals for eligibility for SFDS based on family size and income and charge accordingly.

21) Can health centers require proof of application for insurance or other documentation (e.g., exemptions) before offering services on a sliding fee discount scale (SFDS)?

Health centers must continue to provide eligibility assistance by educating consumers about affordable insurance options, including the benefits that extend beyond the services provided by the health center (e.g., access to specialty care and hospitalization), and providing assistance with enrollment for eligible individuals. However, if a current or new patient is not able to, is exempt from, or chooses not to enroll, the health center must assess the patient's eligibility for the SFDS based on family size and income and, as appropriate, charge the patient in accordance with the health center's SFDS for the service(s)

provided.

22) If a patient below 200% of the Federal Poverty Guidelines is enrolled in a Qualified Health Plan (QHP) with which the health center does not have a contract and that patient wants to continue to receive services at the health center, must the health center provide those services on a sliding fee discount scale (SFDS)?

Yes. If after being informed of the benefits of receiving care from a provider in their QHP network and how to access that care, the patient chooses to continue receiving care at the health center, the health center must assess eligibility for the SFDS based on family size and income and charge the patient in accordance with the health center's SFDS for the service(s) provided.

23) Are we required to charge patients for services provided at the health center in accordance with our health center's sliding fee discount schedule (SFDS) if they are auto-assigned to another Medicaid managed care provider and either choose not to or have not yet been reassigned to the health center?

Consistent with previously published responses the health center would inform/educate the patient regarding their option to receive care from the primary care provider to whom they have been assigned. The health center may provide assistance with the process of reassignment if requested by the patient to do so and if this is consistent with health center policies and procedures and any additional guidance provided by the state Medicaid agency or state law. If the patient chooses to receive care from the health center prior to the effective date of a reassignment or chooses not to pursue reassignment, the health center would assess eligibility for SFDS in accordance with health center policies and procedures and charge the patient in accordance with the health center's SFDS for the service(s) provided.

24) May health centers offer different sliding fee discount scales (SFDS) based on eligibility for subsidies through the Marketplace or insurance status?

No. Sliding fee requirements apply to individuals based solely on income and family size. Therefore, individuals of comparable income and family size would need to be treated uniformly. See the response to FAQ #21 below for a specific example.

25) Are patients who are covered by a QHP eligible for sliding fee discounts? If so, how is the sliding fee discount schedule (SFDS) applied?

Health centers are required to determine patient eligibility for sliding fee discounts based solely on the patient's income and family size. Some of these eligible patients may also have third party health insurance, such as a qualified health plan (QHP), which does not cover or only partially covers health care services, resulting in "out-of-pocket" costs (e.g., co-insurance or co-pays). In these cases, the health center would apply the sliding fee discount by charging the patient in a given SFDS pay class an amount no greater than what would be charged to a patient that has no public or private insurance. For example, insured health center *Patient A* receives a health center service. His/her insurance co-pay, under his/her QHP, is indicated to be \$60 for this service. The health center has also determined that this patient is at 160% of the federal poverty guidelines (FPG), and thus, also qualifies for the health center's SFDS. Under the SFDS, a patient at 160% FPG would be charged \$45 for this same service. Thus, the health center would have *Patient A* pay no more than \$45 out-of-pocket, consistent with its SFDS.

Please note that health centers are responsible for ensuring adherence to Federal and state laws and regulations and for following the terms and conditions of their contracts with third party insurers. Health centers with questions on the applicability of federal and state law and/or the terms and conditions of their private payor contracts should consult with private legal counsel.